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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Lonsurf[®] Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Colorectal cancer					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information:					
Does the patient have metastatic colorectal cancer (mCRC)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select if the patient has had trial and failure, intolerance, or contraindication to the following:					
<input type="checkbox"/> Fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy (e.g., FOLFOX, FOLFIRI, FOLFOXIRI)					
<input type="checkbox"/> Anti-VEGF therapy (e.g., Avastin [bevacizumab], Zaltrap [ziv-aflibercept])					
<input type="checkbox"/> Anti-EGFR therapy (e.g., Vectibix [panitumumab], Erbitux [cetuximab]), if the patient has KRAS wild-type tumors					
Does the patient have KRAS mutant tumors? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is Lonsurf prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Reauthorization:					
Does the patient show evidence of progressive disease while on Lonsurf therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Quantity Limit Requests:					
What is the quantity requested per MONTH? _____					
What is the reason for exceeding the plan limitations?					
<input type="checkbox"/> Titration or loading dose purposes					
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)					
<input type="checkbox"/> Requested strength/dose is not commercially available					
<input type="checkbox"/> Other: _____					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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